

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-013096

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3279

STATE FILE NUMBER

FILED MAR 28 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

ST. LOUIS, MO.

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived at institution: Residence before admission)
a. STATE MO. b. COUNTYc. CITY
OR
TOWN

ST. LOUIS

Inside Limits
Yes ☐ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

ST. LOUIS CITY HOSP. #1

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

2010 SO. BROADWAY

Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

CARL

Middle

CARLSON

Last

4. DATE
OF
DEATHMonth
FEB.

Day

16, 1963

Year

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☐
Widowed ☐ Divorced ☒

8. DATE OF BIRTH

6/15/01

9. AGE (last birthday)

61

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HR
Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (City and state or country)

ILL.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

JOHN

13b. MOTHER'S MAIDEN NAME

CAROLINE STRONG

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NO

17. INFORMANT

ST. LOUIS CITY HOSP. #1.

Address

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO (b)

DUE TO (c)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.Abdominal Aortic Aneurysm
Atherosclerosis
274xINTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

11-25-62

to

2-16-63

and last saw her
him alive on 2-16-63

Death occurred

a.m.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

1515 LAFAYETTE

22c. DATE SIGNED

2-16-63

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

3-1-63

23c. NAME OF CEMETERY OR CREMATORY

Rowland-Aker Mortuary Service

Anatomical Board

23d. LOCATION (City, town, or county)

St. Louis, Mo.

(State)

24. FUNERAL DIRECTOR'S ADDRESS

St. Louis 10, Mo.

25. DATE RECD. BY LOCAL REG.

MAR 21 1963

26. REGISTRAR'S SIGNATURE

Loan Smith, M.D.

SCHEDULE
USE
BLACK INK
OR
TYPEWRITER RIBBONAMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.